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Medical traditions and chronic disease in Ethiopia: a story of wax and gold?

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Abstract

Effective medical care for non-communicable diseases (NCD) remains lamentably poor in Ethiopia and many low-income countries. Consequently, where modern medicine does not reach or is rejected, traditional treatments prevail. These are fragmented and esoteric by nature, and their understanding of illness is so fundamentally different that confusion proliferates when attempts are made to introduce modern medical care. Ethiopia is host to a variety of longstanding medical belief systems that coexist and function together, where modern medicine is often viewed as just another choice. This multiplicity of approaches to illness is accompanied by the Ethiopian custom of weaving layers of meaning, often contradictory, into speech and conversation – sometimes referred to as 'wax and gold', the 'wax' being the literal and the 'gold' the deeper, even hidden, meaning or significance. We argue that engagement with traditional belief systems and understanding these subtleties of meaning could assist in more effective NCD care.

Keywords

Non-communicable diseases, traditional medicine, belief systems

Quotation

'...Hospitals have always been regarded with suspicion. Many will resist attending...so long as there is some alternative – whether it is traditional medicine, a holy fountain or the Adbar.'[1]

'It is only after the bitter roots have failed to cure the ailment; after the holy water has gone amiss, refusing to wash away the evil eye; and after the sacred tree has failed to defeat the devil, the patient is sent to the sanatorium. It will then take a miracle to keep the individual alive. No wonder hospitals were reputed to be places of the dying.'[2]

Discussion

The rising prevalence of chronic non-communicable disease (NCD) in Ethiopia and other low-income countries in sub-Saharan Africa have led to a plethora of 'top-down' policies and initiatives to expand and improve existing medical services. Under the aegis of the World Health Organization's (WHO) global action plan, which sets out priorities and targets for NCD control, these are: surveys of disease prevalence and their linked risk factors; strengthening leadership and national capacity; the creation of health-promoting environments; and the extension of primary healthcare systems. Yet in many of the poorest countries, the impact of these has been muted, especially in rural areas where most of the population still live. There are several reasons for this: the notorious underresourcing of formal health systems; the lack of qualified medical staff; and the understandable tendency to focus on communicable diseases. However, an important but greatly neglected factor is the tension between modern medicine and traditional systems. Families and communities who bear the primary responsibility for the care of chronic disease patients quite naturally resort to indigenous forms of therapeutic knowledge. Being the more recent arrival, modern medicine is perceived by these communities through the prism of these belief systems. And yet studies of how these worldviews have absorbed the concepts and practices that

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have been introduced by modern medicine are still in their infancy.[4–6]

In Ethiopia, the ratio of traditional healers to population is 1:500 compared with 1:40,000 for doctors. It is no surprise, therefore, that healing traditions, some of which have a literary lineage that is centuries old, are used by over 80% of the population.[7] The remarkable depth and longevity of these ideas are well-illustrated by the Ethiopian Jewish émigrés who, after several decades of access to modern medicine in Israel, still come back to Ethiopia seeking cures for a variety of chronic diseases.

Ethiopia's population is heir to a multiplicity of belief systems.[4] 'Healer shopping' – or seeking treatment from a succession of practitioners using a variety of techniques, some religious, some secular – is the norm for many patients, who may only attend the chronic disease clinic as a fourth or fifth choice, and only if all else fails.[8] Unfortunately, a large number of patients who could benefit from the clinic never even attend. The gap between patient expectation and what the clinic presumes to offer leads to high default rates, patient non-compliance with treatment and a cycle of disappointment. Effective long-term treatment of NCDs is therefore compromised or ineffective. Clearly, if the ambition of universal health coverage is going to be effective, policies and practices need to be shaped to take account of these disparities.

Fundamental to such policy-making is an appreciation of how the concepts of health and disease are understood by the community. It is often difficult for a biomedical practitioner to realise just how different a patient's conception of wellbeing and illness may actually be. This is particularly apparent when considering the aetiological reasoning of what determines the human condition which, in Ethiopian culture, involves a well-developed supernatural dimension. Another difference is that, contrary to modern perceptions, disease may actually be viewed as something that enriches one's way of life. Overcoming illness, tolerance of privation, for example by prolonged fasting, and coping with adversity in general are means of penance and signify strength of, and adherence to, the faith. Finally, Western medical terms for certain conditions and diseases do not always have parallels in the lexicon of local traditional medicine. Even when they do, they frequently do not match up as a result of different ontological perspectives. Conversely, traditional medicine may recognise conditions which have no Western equivalent. For example, diabetes and its symptoms do not correspond to any named condition in traditional Ethiopian medicine, while conditions such as the *Kurenya* sickness comprise a variety of symptoms which are non-existent in modern medical taxonomy.

The gulf between traditional and modern concepts of disease is even greater when considering the issue of treatment. Most local healers will claim to cure any kind of sickness. Yet the majority of chronic diseases of importance in sub-Saharan Africa are by their nature, incurable, requiring long-term management and regular clinic follow-up to monitor progress. One should not be surprised that chronic disease patients in Ethiopia attending NCD clinics frequently exhibit a sense of disappointment that a cure is not being offered. This disparity between world-views is well illustrated by the very word used in modern Ethiopia to describe pharmaceuticals, *medhanit*, which also means in Old Ethiopic both 'health' and 'redemption' (or 'salvation'), demonstrating deep-set theological sensibilities. To be sure, one of the Ethiopian epithets of God is *medhane 'alem*, or 'The Redeemer/Healer of the World'; spiritual redemption is therefore often viewed as more significant than actual physical healing. Attempts to find appropriate wording to describe clinical treatments are, unsurprisingly, fraught with potential misunderstandings.

Two illustrations clearly describe the kind of disparity that emerges. The first arose during a campaign to promote 'life-extending' retroviral drugs for HIV treatment in Ethiopia (Y Mamo, personal communication 2015). The meaning might seem evident, but it soon emerged that there was a surge in demand for retroviral drugs to treat the elderly and feeble. The Ethiopian Church authorities rapidly responded demanding that the campaign change its wording, as only God could extend life. Another example came to light at a mother and child birthing clinic (S Levene, personal communication 2015); during a health education session given to new mothers, two images were presented: one had a picture of a baby's bottle, while the other had the same bottle with a fly on the teat and a big 'X' over it. When asked which was the proper one to choose, the women, without exception, opted for the image with the fly on the teat and the 'X' across it. When asked why this one had been selected, they answered that, as it had a (holy) cross upon it, surely it was the right one.

A quote from another informant – a patient – further illustrates our point: 'I was diagnosed as having diabetes. It is said that it could be healed with holy water, so I wanted to try that before I started the medicine. I had a long debate (with the medical practitioners) because I refused to start the medicine and wanted to leave the clinic to try holy water.' Most diabetes patients, however, as well as patients with other chronic diseases did admit that holy water could not do what modern medicine did, but were adamant that holy water was a necessary addition, providing something extra that modern medicine could not – redemption.

Can these world-views, traditional and modern, match up in making sense of each other's taxonomies?

On one side is the view that, apart from cases where a herb or a physical praxis might by chance be effective, these traditional belief systems are on the whole fictitious, misguided, often harmful and, to a great extent, a sham.[9] On the other side is the approach currently favoured by the WHO – one of regulation and integration, while recognising the contribution of traditional medicine to healthcare.[10] This includes the development of training programmes, registration of practitioners, regulation of safety and efficacy, and the licensing of traditional medicines. Yet one must question to what extent such praxis and belief can be 'governed' and controlled, as doing so is likely to remove or detach it from that very complex of elements that make it 'traditional'. Making use of manpower by contemporary official systems is surely both inevitable and necessary. At the same time, elements appropriated from traditional forms of praxis are thus detached from the social and knowledge base that give force and power to 'tradition' – continuous, yet fragmented stretching back into the mists of time.

Donald Levine[11] argues that duality of meaning, as exemplified by the poetic omit tradition, is a fundamental characteristic of Ethiopian communication at all levels. Mohammed Girma suggests this tradition is 'a philosophical foundation for an Ethiopian hermeneutic' that pervades not just the personal but also the greater social and political arenas. Ethiopia's poetic tradition, which is known as 'Wax and Gold' (*Senena-Werq*) is one that has long been used to characterise being 'Ethiopian'.[11,12] The simile for this tradition is derived from the lost wax (*cire perdu*) casting technique used in the production of gold jewellery and other objects. Here the form of the object is initially fashioned in wax; it is then invested in heat-resistant material, usually a type of plaster or ceramic. The invested wax is then fired during which it melts, leaving behind a negative impression of its shape in the mould. Into this mould, molten gold is poured to take the form of the shape of the original object.

In poetic terms, the allusion is to a duality of meaning that the skilled Ethiopian Qene poet/scholar invests into his literary creation. The hidden meaning is the gold, which is mystical or even contradictory to the plain or literal meaning. A skilled Qene poet might study up to 35 years to perfect his craft, which is appreciated as one of the finest of Ethiopian forms of lore.

We argue that this expectation of duality of meaning is a useful metaphor in exploring the semantic conundrum that is so pervasive in communication. Such a concept is helpful in appreciating medical issues where a variety of medical belief systems coexist and function together. The 'wax' represents the apparent meaning, and the 'gold' the deeper, often hidden, meaning. The 'gold' meaning conjured in the mind of the patient may not always be as obvious as one might initially have expected.

Two prerogatives should take precedence in terms of any research that aims to provide a better understanding of the nature, history and dynamics of the 'traditional' medical systems in Ethiopia. First, there is a need for the recording and understanding of 'traditional' medical belief and praxis systems as dynamic forms of knowledge and culture that have evolved, and are still evolving. As their equivalents have done in other parts of the world, they steadily change, transform and may, in part, disappear. The second is to determine the best use of these systems and what their practitioners have to offer as a resource in the scheme of integration into a 'modern' biomedical health system/service.

Current treatments and the beliefs that underpin traditional medical world-views in Ethiopia form little or no part of health education curricula, are poorly understood and are mostly *de facto* ignored by most medical staff who are, in any case, overloaded by clinical demands. Making such knowledge available could lead to novel and more effective ways in the approach to and treatment of patients. It could help in explaining disease aetiology and pathogenic processes in terms that are understandable to patients (and numbers of medical staff) with traditional mindsets. It could help explain what is achievable, what the limitations are of current therapies for chronic disease, where traditional treatments could offer a valuable adjunct and, conversely, which traditional treatments to avoid. Perhaps, more importantly, there is a need to work with the wider community, asking the rarely asked question as to how modern medical care is perceived and how it could find greater acceptance in the population.

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Comparison of Lichtenstein inguinal hernia repair with the tension-free Desarda technique: a clinical audit and review of the literature

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Abstract

Ours was a retrospective chart review of all elective open inguinal hernia repairs performed in a single unit at King Edward VIII Hospital, South Africa over an 18-month period. Comparison was made regarding duration of operation, length of hospital stay and complications such as pain, haematoma formation and recurrence between the Lichtenstein and Desarda techniques. The latter was noted to have a shorter operative time and avoided cost and possible complications of mesh usage, which are significant in resource-deprived settings. A larger comparative study with longer follow-up is needed to evaluate the wider suitability of the Desarda repair.

Keywords

Open inguinal hernia repair, Lichtenstein, Desarda, poor resource setting

Introduction

The history of hernias is as old as the history of surgery, with the first repairs dating to 1559.[1] Inguinal hernias rank among the commonest of all hernias and surgery is the only definitive treatment. In understanding the pathological process of the development of a hernia, anatomical considerations have largely been concentrated on, and the emphasis is thus on restoring anatomical integrity, mostly (in the context of inguinal

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